**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor Name and Address:<br>EDINBURG REIONAL MEDICAL CENTER<br>3255 WEST PIONEER PARKWAY<br>ARLINGTON TX 76013 | MFDR Tracking #: M4-07-4521-01 |
| | DWC Claim #: |
| | Injured Employee: |
| Respondent Name and Box #:<br>AMERICAN HOME ASSURANCE CO<br>Box #: 19 | Date of Injury: |
| | Employer Name: |
| | Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We have filed an MDR for this service because we believe that the reimbursement received for this trauma admit (Dx 886.0) was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare DRG rate for this service is $7,235.02 times 140% is $10,129.03. We only received $2236.00 in payment for this service-seriously below even the DRG rate alone. We request that the insurance carrier pay the balance due of $7893.03."

**Amount in Dispute:** $7893.03

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Using the per diem method, this two-day surgical admission qualifies for $2,236.00 ($1,118.00 per day) for two days in reimbursement. See Rule 134.401(c)(1). The carrier's EOB dated September 13, 2006 recommended reimbursement in the sum of $2,236.00. I am attaching a copy of it as Exhibit A. It remains the carrier's position that it has reimbursed the provider consistent with the Division rules and that the provider is not entitled to any additional reimbursement."

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 5/16/2006 through 5/18/2006 | 42, BL | Inpatient Hospital Services for Trauma Admission | $7893.03 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 15, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 42-Charges exceed our fee schedule or maximum allowable amount.
   - BL-For all reconsiderations/adjustments/payment dispute requests please submit a copy of this EOR.
   - BL-This bill was reviewed in accordance with a First Health owned network contract.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the provider's PPO contract.

- BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
- 42-This line was included in the reconsideration of this previously reviewed bill.

2. The Respondent raised the issue of a PPO contract; however, a review of the submitted EOBs does not support a PPO reduction was taken. Neither party submitted a copy of a contractual agreement to support this EOB denial; therefore, the disputed services will be reviewed in accordance with §134.401.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67on the hospital bill finds that the principle diagnosis code is listed as 840.1. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(A).
7. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
8. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement states that "We have filed an MDR for this service because we believe that the reimbursement received for this trauma admit (Dx 886.0) was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare DRG rate for this service is $7,235.02 times 140% is $10,129.03. We only received $2236.00 in payment for this service-seriously below even the DRG rate alone. We request that the insurance carrier pay the balance due of $7893.03."
   - The requestor does not discuss or explain how payment of 140% of Medicare rate would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.

- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION/ORDER:**

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|---|---|---|
| | | 9/16/2010 |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 9/16/2010 |
| Authorized Signature | Medical Fee Dispute Resolution Manager | Date |

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**